
In the Matter of the Compensation of
DOUGLAS M. SULLIVAN (IN RE CULLEY), Claimant
WCB Case Nos. 18-01533, 17-04566
ORDER ON REMAND
Dale C Johnson, Claimant Attorneys
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Reviewing Panel: Members Ousey and Ogawa.¹

This matter is before the Board on remand from the Court of Appeals.² *Sullivan v. SAIF*, 319 Or App 14 (2022). The court has reversed the Board's prior order, *Robert J. Culley*, 72 Van Natta 721 (2020), that affirmed that portion of an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's new/omitted medical condition claim for a left L5-S1 lumbar radiculopathy condition. Reasoning that the Board's order, including its rejection of the treating physician's opinion, was not supported by substantial evidence or substantial reason, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," as summarized and supplemented below.

In 2013, before the decedent's work injury, he treated for bilateral sciatica and low back pain, with pain radiating down both legs to the knees. (Exs. 1, 3, 5, 11-17, 21, 24, 25). A 2013 lumbar spine MRI showed "multilevel disc disease producing relatively minimal canal, but up to moderate neuroforaminal narrowing as described above." (Ex. 2-2). There were also disc bulges at L3-4 and L4-5, which were described as minimally indenting the ventral aspect of the thecal sac. (*Id.*) Finally, there was nothing remarkable with respect to L5-S1. (*Id.*)

Beginning in April 2014, the decedent began treating with Dr. Essex, his primary care physician, for left foot pain, which began after treatment for a left knee Baker's cyst. (Ex. 5). At that time, the decedent was also experiencing low back pain, and he sought and obtained several months of chiropractic treatment for

¹ Member Woodford was a member of the initial reviewing panel. Because she is no longer with the Board, Member Ogawa has participated in this review.

² Because claimant is deceased, the personal representative of his estate was substituted as the claimant.

his foot and for low back pain, including mild to moderate pain in the sacrum region. (Exs. 5—9). A chiropractic exam revealed positive straight leg raise for left low back pain, as well as decreased sensation in the dermatomes of L5 and S2. (Ex. 5). The chiropractor's primary diagnosis was "lumber spine sprain/strain." (Exs. 11—17, 21—25). In May 2014, Dr. Essex referred the decedent to Dr. Zilkoski, an orthopedic foot specialist, for treatment of constant pain in his left foot. (Ex. 10).

In June 2014, Dr. Zilkoski noted that the decedent experienced left foot pain and numbness primarily about the MTP joints with some hindfoot pain that was electrical in nature. (Ex. 18-1). She noted that the decedent's sharp electrical shooting pains had decreased over time. (*Id.*) Dr. Zilkoski recommended an MRI, which she interpreted as showing a stress reaction in the calcaneus and some atrophy of the abductor digiti minimi. (Ex. 20-3). She recommended that the decedent follow up with primary care for evaluation of his back and consider nerve conduction studies. (*Id.*)

In July 2014, the decedent reported that his left foot discomfort was mild and had occurred with occasional (25 to 50 percent) regularity since his previous treatment. (Ex. 25). He did not resume treatment thereafter.

On July 29, 2015, the decedent, who worked as a detective at the time, sustained a work-related injury when he was hit by a bicyclist as he was walking through a parking lot. (Exs. 25A, 26A). The bicycle reportedly struck the decedent in the back of his left lower leg, which twisted his left knee inward and caused him to fall. (Exs. 26, 27). He described pain in his bilateral knees, left elbow, and left ankle, but he did not initially report any foot or back pain. (Exs. 25A-3, 26-5-7, 27-1). His claim was accepted for left knee strain, right knee abrasion, left knee abrasion, left elbow abrasion, and left foot comminuted fracture of the third proximal phalanx. (Ex. 59).

In early August 2015, the decedent began treating with Dr. Yao for his "left" knee after he was hit by a bicycle. (Ex. 28-1, -5). On September 8, 2015, he returned for treatment of both knees, but also reported that he had recently experienced some numbness on the bottom of his "left" foot, as well as sharp, frequent pain in the outer aspect of the fourth and fifth metatarsal region of the "right" foot, which began roughly two weeks following his "MVA." (Ex. 29-1, -4). Dr. Yao noted that the decedent had previously seen Dr. Zilkoski "for this," a reference to Dr. Zilkoski's treatment of the decedent for foot pain in 2014. (Ex. 29-1).

On that same date, Dr. McCormick, an orthopedist, evaluated the decedent for left foot symptoms. (Ex. 31-1). The history included an onset of left foot numbness since an injury in which decedent's left calf was struck by a bicycle from behind, and that he had been treated two years ago for similar plantar forefoot numbness. (*Id.*) Dr. McCormick noted that the decedent's pain had previously receded "without treatment" and that his left foot numbness had comparatively increased after the work injury. (*Id.*) The decedent described his left foot as feeling like it was a sack, with numbness most present when sitting and worse when lying down. (*Id.*) The decedent also reported that, two weeks ago, he began experiencing similar pain and numbness in the right foot over the base of the third and fourth "MTP's." (*Id.*)

Dr. McCormick referred the decedent for a nerve conduction study with Dr. French, a physical medicine and rehabilitation specialist. (Exs. 31-4, 33). Dr. French performed "NCV" testing, but clarified that it was a "no needle exam." (Ex. 33-1). Thus, he did not document "EMG" findings. (Ex. 33-2). He found that decedent's left and right lateral plantar motor nerves, as well as the right medial plantar motor nerves, "showed no response." (Ex. 33-1). Ultimately, Dr. French interpreted the electrodiagnostic study as showing an abnormal examination with "delayed/unobtainable plantar nerve conductions, suggesting bilateral tarsal tunnel syndrome." (*Id.*)

On November 9, 2015, Dr. McCormick noted that the nerve conduction study was incomplete due to a lack of needle use, but that the motor neural evaluation showed decreased plantar nerve conduction. (Ex. 34-5). Given this finding, Dr. McCormick concluded that the decedent had tarsal tunnel syndrome, which resulted in a discussion of possible surgical treatment if there was something pushing on the plantar nerve. (*Id.*) Therefore, Dr. McCormick recommended an MRI to evaluate the left foot tarsal tunnel. (*Id.*) A November 30, 2015, left ankle MRI was interpreted as showing an unremarkable tarsal tunnel. (Ex. 35).

In December 2015, Dr. McCormick stated that the decedent was there for a follow up of his left ankle and to review his MRI. (Ex. 37). The decedent reportedly stated that his numbness had worsened and was present throughout the entire bottom of the left foot. (*Id.*) On examination, he had a positive Tinel's at the medial ankle. (Ex. 37-5). Dr. McCormick noted that the MRI did not reveal a mass in the tarsal tunnel, but that it confirmed a diagnosis of neuralgia and neuritis with tarsal tunnel syndrome. (*Id.*) Because there was no mass in the tarsal tunnel, Dr. McCormick indicated that surgery results would be unpredictable. (*Id.*)

Nevertheless, he opined that it was “likely that the nerve responsible for [the decedent’s] numbness [was] likely due to his previously described injury, in which case the nerves would heal eventually on their own[.]” (*Id.*)

In February 2016, the decedent treated with Dr. McCormick, who documented his reports of worsened left foot numbness with numbness into his left great toe. (Ex. 40). The decedent described it as feeling separate from the rest of the left foot numbness and intermittently associated with shooting pains. (*Id.*)

In June 2016, the decedent was evaluated by Dr. Essex for left foot pain and numbness that was not improving. (Ex. 42). Dr. Essex noted that he had previously treated the decedent for very similar symptoms in the year before this work event. (Ex. 42-1). He further indicated that the MRI demonstrated that the nerve was not compressed in the tarsal tunnel. (*Id.*)

In September 2016, the decedent returned to Dr. McCormick, who noted that the decedent had been experiencing numbness over the plantar surface of the foot, but had also developed an area of numbness over the dorsum two months ago. (Ex. 43). Dr. McCormick continued to diagnose left foot neuritis, and noted that the decedent would benefit from a neurological evaluation. (Ex. 43-5).

In October 2016, the decedent began seeing Dr. Herring, a neurologist, for his continued left foot pain and numbness. (Ex. 44-1). The decedent denied back pain, but reported left foot numbness that began within days of his bicycle injury. (*Id.*) The numbness was provoked by sitting or by lying on his back. (*Id.*) He also reported experiencing shooting electrical pains into the left big toe for approximately a year before the work incident, but that the symptoms had resolved on their own and were not present at the time of the work injury. (*Id.*) On examination, the decedent had a positive straight leg raise on the left with some tenderness in the left lateral lumbosacral region. (Ex. 44-3). Dr. Herring found decreased pinprick at the bottom of his left foot and the left lateral foot, with decreased pinprick throughout, including the lower medial leg, and diminution to vibratory sensation in the left foot. (Ex. 44-4). The decedent had some proximal weakness with a single leg deep knee bend on the left, and a clear decrease in the ability to left toe walk. (*Id.*)

Ultimately, Dr. Herring diagnosed lumbar radiculopathy on a clinical basis, which he described as the most likely explanation for the decedent’s left lower extremity findings. (*Id.*) He attributed the condition historically to the work-related bicycle injury in which the decedent was knocked to the ground. (*Id.*)

Dr. Herring explained that, even though the decedent did not have specific low back pain at the time of the injury, the evolution of his sensory findings, weakness, and the presence of positive straight leg raising led him to suspect lumbar spine etiology. (*Id.*) He recommended further imaging of the lumbosacral spine and electrodiagnostic testing. (*Id.*) He also diagnosed left plantar flexion weakness, which he attributed to the work injury, and gait disturbance that he attributed to the lumbar radiculopathy diagnosis. (*Id.*)

On November 7, 2016, Dr. Herring's associate Dr. Balm, a neurophysiologist, performed an electrodiagnostic study of the decedent's left foot, including nerve conduction studies and a thorough needle examination. (Ex. 45). Dr. Balm reported findings of "electrophysiologically mild, old, or chronic inactive left S1 radiculopathy." (*Id.*) He concluded that the study provided no electrophysiologic evidence for the presence of any ongoing active radiculopathy, nor for the presence of lumbosacral plexopathy, sciatica, or other mononeuropathy affecting the left lower extremity. (*Id.*)

The decedent underwent a lumbar spine MRI on November 11, 2016, which showed mild multilevel spondylosis and mild L2-3 spinal stenosis with moderate bilateral lateral recess narrowing and no foraminal narrowing. (Ex. 46). All levels had facet degenerative changes and some degree of central disc bulging with no compression of the nerve roots, including L5-S1. (*Id.*) During and after that MRI, the decedent began to experience left-sided low back pain and pain radiating into his leg. (Ex. 47-1).

On November 17, 2016, Dr. Herring stated that the decedent's symptoms and findings continued to suggest lumbar radiculopathy, with his MRI showing no clear definite etiology, and his electrodiagnostic studies remarkable for S1 findings. (Ex. 47-4). Because the decedent's symptoms persisted and had begun to include back pain, Dr. Herring recommended more imaging and the opinion of a spine surgeon. (*Id.*) Dr. Herring added the diagnosis of old left S1 sacral radiculopathy based on electrodiagnostic study findings that he described as remarkable for abnormal S1 findings that were not acute, but clarified that the decedent's date of injury was nearly a year and a half ago. (*Id.*) An x-ray confirmed mild degenerative changes of the lumbar spine without dynamic instability. (Ex. 48).

On February 10, 2017, Dr. Truong performed a closing examination for the decedent's accepted conditions. (Ex. 49). On examination of the left lower extremity, he noted decreased sensation to light touch and pinprick sensation

involving the left upper calf and into the lateral calf, ankle, and foot. (Ex. 49-5). Dr. Truong also found decreased sensation to light touch and pinprick sensation involving the right distal calf/ankle and foot. (*Id.*)

On February 16, 2017, Dr. Herring reviewed the decedent's additional imaging and noted that attempts to refer him to neurosurgery were unsuccessful. (Ex. 50-1). The decedent reported that he was informed by staff of Dr. Noonan, a spine surgeon, that Dr. Noonan had reviewed the decedent's records and did not feel that he was a surgical candidate or that he needed to be seen. (Ex. 50-1, -4). Dr. Herring noted that the decedent's left foot pain could be caused by either a lumbar radiculopathy or, given the mechanism of injury in which the decedent was struck by a bicyclist possibly in the buttock, potentially piriformis syndrome. (Ex. 50-4). Dr. Herring added the diagnosis of piriformis syndrome, and noted that the decedent's sacral radiculopathy had differential diagnoses of irritation of his S1 nerve root versus posttraumatic piriformis syndrome. (Ex. 50-4-5).

On April 11, 2017, the decedent followed up with Dr. Herring, who noted differential diagnoses of piriformis syndrome and lumbar radiculopathy/old left S1 sacral radiculopathy. (Ex. 53-4-5). Dr. Herring opined that, given the mechanism of injury, the decedent's symptoms may have multiple etiologies. (Ex. 53-4). He attributed either condition historically to the bicycle injury. (Ex. 53-5).

The decedent's counsel wrote to Dr. Herring, asking for a precise diagnosis for the decedent's low back problems and, given the history, whether his work injury was a material cause of his need for treatment or disability for his low back condition. (Ex. 52A). In response, Dr. Herring opined that his differential diagnoses included posttraumatic lumbar radiculopathy (*i.e.*, nerve root irritation) as a result of the trauma or posttraumatic piriformis syndrome, historically a direct result of the decedent's trauma. (Ex. 53A-1). Dr. Herring explained that the decedent believed that his left buttock area was the site of one of many areas of impact. (*Id.*) He attributed the material and major contributing cause of the need for treatment, whether secondary to lumbar nerve root irritation/lumbar radiculopathy or posttraumatic piriformis syndrome, to the decedent's work injury. (*Id.*) With respect to Dr. Balm's November 2016 electrodiagnostic finding of mild old chronic inactive left S1 radiculopathy, Dr. Herring concluded that it was uncertain whether this condition was related to the decedent's injury. (*Id.*) Finally, regardless of whether the decedent had a preexisting low back condition, Dr. Herring opined that his work injury was the direct cause of his new onset of neurologic symptoms and need for treatment related to his current symptoms. (Ex. 53A-1-2).

The decedent continued to treat with Dr. Herring. On May 26, 2017, Dr. Herring noted that he could not, on a clinical basis, be absolutely certain whether the decedent's differential diagnoses of lumbar radiculopathy or posttraumatic piriformis syndrome were the cause of his current symptoms, and that there may be a component of both in light of the mechanism of injury. (Ex. 54-4). On July 11, 2017, Dr. Herring reiterated this opinion. (Ex. 55-1). However, he also stated that that date's examination findings were most consistent with a lumbar radiculopathy as the etiology for the decedent's left leg symptoms and not much to suggest an ongoing piriformis syndrome. (Ex. 55-4). Thus, he concluded that the decedent was "more likely than not" dealing with a nonsurgical lumbar radiculopathy. (*Id.*) However, Dr. Herring clarified that the old left S1 radiculopathy may or may not be related to his most recent injury, but that it was "seeming more likely than not that it is." (Ex. 55-4-5).

On September 14, 2017, Dr. Herring noted that the decedent reported a marked increase in back pain following a prolonged car ride that took place on September 5. (Ex. 57-1). He noted that the decedent had an increase in left leg numbness, more so in an L5 distribution. (*Id.*) The decedent experienced electric shock-like sensations across the low back that increased with certain sitting positions. (*Id.*) The pain was from the back into the left hip, and then starting at the knee going down the medial leg to the medial left foot. (*Id.*) On examination, the decedent had marked allodynia superimposed on numbness in areas of an L5 distribution, with decreased pinprick in an S1 distribution on the left. (Ex. 57-4). Dr. Herring opined that the decedent's lumbar radiculopathy had "significantly worsened, now involving the left L5 distribution." (*Id.*)

Dr. Rosenbaum examined the decedent on SAIF's behalf on October 2, 2017. (Ex. 58). The decedent reported that he was experiencing left foot numbness and low back pain, which had developed after his work injury. (Ex. 58-8). Dr. Rosenbaum's examination revealed moderate pain to palpation at L5-S1 and L4-5, moderate left trochanteric pain, bilateral sacroiliac pain, and moderate left sciatic notch pain. (Ex. 58-9). He also found decreased pin and touch perception in the sole of the dorsum of the left foot and intermittently to the left lateral calf, as well as decreased pin perception in the lateral aspect of the right foot. (*Id.*)

Ultimately, Dr. Rosenbaum could not identify that the decedent had a radiculopathy on the basis of history, physical examination or imaging studies, noting in particular that the imaging studies demonstrated no nerve root compression. (Ex. 58-10, -12). Dr. Rosenbaum believed that the imaging

study findings were consistent with the degenerative process and were not acute. (Ex. 58-10). Although he stated that the decedent's mechanism of injury had the possibility of causing a lumbar radiculopathy, Dr. Rosenbaum concluded that there was no evidence in the medical record, including within the first year following the incident, that a lumbar radiculopathy or radiculitis occurred from the injurious event. (Ex. 58-11).

On October 9, 2017, SAIF denied the decedent's new/omitted medical condition claim for left L5-S1 lumbar radiculopathy, and he filed a request for hearing. (Exs. 56, 59; Tr. 3-4).

On October 23, 2017, the decedent returned to Dr. Herring, providing a copy of Dr. Rosenbaum's report. (Ex. 60). The decedent noted that, during his examination with Dr. Rosenbaum, he switched from toe walk to heel walk, lost his balance, and fell against Dr. Rosenbaum, yet Dr. Rosenbaum described his gait as normal. (Ex. 60-1). Dr. Herring disagreed with Dr. Rosenbaum's opinion, stating that the decedent's onset of symptoms was "coincident with a work injury where he was struck by a heavy bicyclist with a mechanism of injury that would certainly be consistent with a subsequent lumbar spine injury." (Ex. 60-4).

On November 10, 2017, Dr. Herring reviewed the decedent's interim November 6, 2017, repeat lumbar MRI, stating that there was no MRI correlation for his current symptoms. (Ex. 62-4).

On December 19, 2017, the decedent was evaluated by Dr. Moore for pain management. (Ex. 63). Dr. Moore opined that his left lower extremity symptoms and numbness in the bottom of the foot were related to the L5-S1 disc bulge. (Ex. 63-5).

On January 23, 2018, Dr. Rosenbaum agreed that lumbar radiculopathy is a specific condition caused by the compression of a nerve root due to bulging, protruding or extruding disc material, or ligament and bone overgrowth that alters the functioning of the nerve itself. (Ex. 66-1-2). He explained that signs of impingement are determined through clinical examination demonstrating neurological deficits such as motor, sensory, or reflex loss in expected dermatomal distributions in the leg consistent with the specifically affected nerve root. (Ex. 66-1). Dr. Rosenbaum opined that the decedent's lumbar MRI did not demonstrate pathology that would indicate nerve root compression, displacement, or impingement at any level. (Ex. 66-2).

Moreover, Dr. Rosenbaum noted that the decedent did not have neurological signs of nerve root compression, nor did he have historical subjective complaints of the signs of nerve root compression. (*Id.*) He specifically disagreed with Dr. Herring's opinion that the decedent had clinical evidence of lumbar radiculopathy, and explained that neither his chart notes nor those of any other examiner indicated lumbar radiculopathy in a specific dermatomal pattern as evidenced by motor, sensation, or reflect loss. (*Id.*)

In May 2018, Dr. Herring wrote to decedent's counsel, stating that the decedent had ongoing lumbar pain that "historically" was related to his work injury. (Ex. 73). He opined that "back pain or lumbar spine pain" should be part of his claim. (*Id.*)

In July 2018, Dr. Herring noted that the decedent had back injections (performed by Dr. Moore) that were described as transitory in effectiveness. (Ex. 77-1). Dr. Herring reiterated that the decedent's pain generator was likely nerve root irritation as a result of his trauma. (*Id.*) He noted that the decedent's symptoms and signs were consistent with posttraumatic nerve root irritation, and that, although a surgical lesion was not identified, it did not disprove the presence of focal irritation or inflammation. (*Id.*) Moreover, he noted that the decedent's abnormal electrodiagnostic studies were consistent with lumbar radiculopathy. (*Id.*) Dr. Herring explained that his earlier examination findings were consistent with a lumbar radiculopathy diagnosis, including asymmetric ankle jerk (decreased on the left), positive straight leg raise, abnormal sensory findings, and weakness of plantar flexion. (*Id.*) Finally, Dr. Herring found Dr. Rosenbaum's opinion "essentially worthless." (*Id.*)

In October 2018, the decedent underwent another lumbar MRI, which demonstrated mild canal stenosis and partial effacement of the subarticular recesses at L2-3. (Ex. 80-1). From L3 through S1, there were minimal broad-based posterior disc bulges without protrusion and the spinal canal and neural foramina remained adequate. (Ex. 80-2).

In November 2018, Dr. Herring reviewed the decedent's recent MRI, noting the findings at L2-3. (Ex. 81-1). On examination, he had decreased pinprick in both an L5 and S1 distribution on the left, normal on the right. (Ex. 81-4). Dr. Herring agreed that there was no surgically addressable lesion on MRI. (*Id.*)

In January 2019, Dr. Herring noted that the decedent's back felt significantly better following Dr. Moore's injection therapy, but that his left foot numbness and pain was stable to slightly worse following the injection. (Ex. 84-1). The examination was relatively unchanged from the last. (Ex. 84-4).

In June 2019, Dr. Button, an orthopedic surgeon, examined the decedent at SAIF's request. (Ex. 86). He explained that radiculopathy meant irritation of a cervical or lumbar nerve that produces pain, weakness, and/or numbness radiating down an extremity. (Ex. 86-12). After reviewing the medical record, Dr. Button noted that the decedent first presented with numbness on the bottom aspect of his left foot six weeks after the work incident, although he had some foot issues similar to this in 2014 for which he sought treatment. (*Id.*) Dr. Button found no evidence of any pain, weakness, or numbness actually radiating down the extremity (except for the foot numbness) until the decedent saw Dr. Herring 14 months after the injury. (*Id.*)

Dr. Button explained that, because there are many causes of numbness in an extremity and the cause was often unknown, to support a diagnosis of radiculopathy, one needed to have "either electrical support from a nerve test, a history or exam consistent with pain, weakness, or numbness radiating down a leg, or it should generally be in conjunction with nerve compression seen in the lumbar spine." (*Id.*) Dr. Button stated that no provider, including Dr. Herring, had detailed findings of nerve root compression, and the decedent did not complain of symptoms radiating down the leg until 14 months after the injury. (*Id.*) In addition, he noted that the decedent had had two electrodiagnostic and nerve conduction studies, neither of which supported radiculopathy. (*Id.*)

For these reasons, Dr. Button opined that it was "medically highly unlikely" that the decedent developed radiculopathy from the work incident. Ultimately, Dr. Button did not diagnose left lumbar radiculopathy, and opined that the work incident was not a material contributing cause of his need for treatment for this condition. (Ex. 86-12, -14).

In August 2019, the decedent followed up with Dr. Herring, who noted that the decedent had been asymptomatic in his left leg radicular symptoms before the work injury, and that he had attended spin classes five nights per week before the injury, but was unable to continue thereafter. (Ex. 87-1). On examination, the decedent had decreased pinprick in an L5 and S1 distribution, but more so in an S1 distribution. (Ex. 87-4). Dr. Herring stated that the decedent did not have functional interference or pain behavior on examination. (*Id.*)

On October 8, 2019, Dr. Herring disagreed with Dr. Button's opinion. (Ex. 88). Dr. Herring stated that he was a neurologist, which is a medical doctor who specializes in treating disease of the nervous system, which included the conditions and symptoms suffered by the decedent. (Ex. 88-2-3). He represented that he was

treating the decedent for an S1 radiculopathy, which he explained was a condition; *i.e.*, the physical status of a human body part. (Ex. 8-3). He noted that the symptoms of the condition may include pain, weakness, tingling, and numbness, and that radiculopathy can be caused by compression or inflammatory changes. (*Id.*)

Dr. Herring stated that, while it was true that there was no MRI evidence of nerve root compression, compression was not the only source of radiculopathy. (Ex. 88-7). He explained that, in the absence of obvious compression, sometimes a tear in the annulus fibrosis will release disc fluid with an inflammatory component that will provoke an auto-immune reaction resulting in radiculopathy of the nerve root, and that such tears do not necessarily show up on MRIs. (*Id.*) In the decedent's case, he believed that the bicycle incident was of sufficient force to "probably cause a small rent in his annulus which leaked irritants and caused chronic inflammatory changes around the S1 nerve root." (*Id.*)

Dr. Herring opined that the work injury was the major contributing cause of the decedent's "S1 radiculopathy" condition. (Ex. 88-5). He based his opinion on the mechanism of injury (a "forceful event"), the decedent's consistent symptoms and credible examinations, the transient relief of symptoms that he experienced after receiving anti-inflammatory steroid injections, and Dr. Balm's abnormal electromyography (EMG) findings that showed objective evidence of S1 radiculopathy. (Ex. 88-4-6, -8). In reaching this conclusion, he explained that Dr. French's earlier nerve conduction velocity (NCV) did not include a needle study (*i.e.*, an EMG), which is used to determine whether a patient is experiencing radiculopathy. (Ex. 88-8). Moreover, he reasoned that the "mild, old" left S1 radiculopathy findings would not mean that the decedent was asymptomatic, and noted that the EMG was performed nearly one-and-a-half years after the work incident and, therefore, would be too late to expect acute findings. (Ex. 88-9).

Although the decedent had experienced prior left toe issues, Dr. Herring noted that the problem had resolved and that the decedent was asymptomatic at the time of the work injury. (Ex. 88-5). In light of the decedent's symptoms of left foot weakness, numbness and pain, a positive straight leg test on the left, and the EMG showing S1 radiculopathy, Dr. Herring concluded that the decedent had a pattern of nerve root symptoms and findings consistent with nerve root irritation, and that, to a reasonable probability, his complaints were consistent with a lumbar radiculopathy related to the work injury. (Ex. 88-4-5).

Dr. Herring did not have concerns with the delay in the decedent's reporting of left foot numbness for "two weeks" when he treated with Dr. Yao on September 8, 2015. (Ex. 88-9). He explained that it was not unusual for patients to expect their symptoms to get better without having to treat with a physician. (*Id.*) Regarding Dr. Button's comments on "gait" examinations, he remained concerned that Dr. Rosenbaum did not document the decedent's fall during the physical examination. (*Id.*)

CONCLUSIONS OF LAW AND OPINION

In upholding SAIF's denial, the ALJ concluded that, even assuming the radiculopathy existed and constituted a claim for a "condition," the opinion of Dr. Herring, claimant's treating neurologist, did not persuasively establish that his work injury was a material contributing cause of the need for treatment or disability for the radiculopathy. In doing so, the ALJ found that Dr. Herring's opinion was inadequately explained, was not based on complete and accurate information, and did not sufficiently respond to the contrary opinion of Dr. Button.

On review, the decedent contended that Dr. Herring's opinion was persuasive and entitled to deference as his long-time treating physician. *Culley*, 72 Van Natta at 721. We disagreed with his contentions and found that the record did not support a conclusion that Dr. Herring had a complete and accurate history. *Id.* at 722. Specifically, we noted that Dr. Essex, who treated claimant before and after the work injury, opined that the decedent had very similar symptoms on examination both before and after the work injury, and that the record did not establish that Dr. Herring was aware of that history. *Id.* Moreover, we noted that, in reaching his conclusion that the decedent's radiculopathy was caused by the work injury, Dr. Herring relied on Dr. Yao's September 2015 chart note, which contained a history that the decedent had recently experienced numbness in his foot two weeks post injury and had seen Dr. Zilkoski for those symptoms. *Id.* Yet, the record demonstrated that the decedent had treated with Dr. Zilkoski before the July 2015 work injury. *Id.* In addition, we concluded that Dr. Herring did not adequately rebut Dr. Button's opinion that there must be more than foot numbness symptoms after the injury to establish the existence of the radiculopathy. *Id.* Moreover, although Dr. Herring hypothesized that claimant sustained a "rent in the annulus" that did not present on MRI, we found that he did not offer additional explanation as to whether claimant's signs and symptoms on examination close in time to the injury fit within a dermatomal pattern for the left L5-S1 radiculopathy condition. *Id.* at 722-23. Because we found Dr. Herring's opinion unpersuasive, we did not accord it deference and, thus, affirmed the ALJ's order. *Id.* at 723.

The Court of Appeals reversed the Board's order. *Sullivan*, 319 Or App at 15. On appeal, claimant contended that the Board's order was not supported by substantial evidence or substantial reason, because it failed, without reason, to defer to the opinion of the decedent's treating physician and did not adequately explain its conclusion that the treating physician's opinion had been based on an incomplete medical history and inaccurate information. *Id.* The court agreed with claimant, concluding that: (1) the Board misread the record with respect to Dr. Herring's reference to Dr. Yao's report of symptoms two weeks after the injury and, thus, the record required a finding that Dr. Herring's opinion was based on accurate information and that the decedent complained of foot pain to Dr. Yao two weeks after the injury; (2) the Board erred in determining that Dr. Herring had an incomplete record because he did not refer in his reports to the decedent's history of and treatment for sciatica in 2013 and may not have been aware of the decedent's prior history of sciatica; *i.e.*, that the record required a finding that Dr. Herring had for his review all of the decedent's medical records and was aware of his history; and (3) the Board erred in discounting Dr. Herring's opinion because he did not adequately explain his disagreement with Dr. Button's view that the decedent had not experienced symptoms of radiculopathy because he stated that, despite the absence of back symptoms immediately following the injury, the decedent's history and diagnostics (including positive leg straightening test, decreased pinprick in the left foot and leg, indicative of sensory loss, and an EMG showing S1 radiculopathy) were indicative of L5-S1 radiculopathy. *Id.* at 21.

Under such circumstances, the court concluded that the evidence in the record did not support the Board's reasons for discounting Dr. Herring's opinion and, therefore, that its findings, including its rejection of the treating physician's opinion, were not supported by substantial evidence or substantial reason. *Id.* at 23-24. Thus, it remanded to the Board for further consideration of the treating physician's opinion. *Id.* at 24.

On remand, claimant renews his contention that Dr. Herring's opinion is persuasive and entitled to deference as claimant's long-time treating neurologist. In response, SAIF asserts that claimant has not persuasively established the existence of the claimed condition, that Dr. Herring's opinion is insufficiently persuasive, and that Dr. Button offered the most persuasive opinion.³ For the following reasons, we find the claim compensable.

³ On remand, SAIF contends that the left L5-S1 radiculopathy is not a "condition," but rather a "symptom" of a condition. Yet, although SAIF specifically raised this contention at the hearing level, it conceded in its brief on Board review that the claimed radiculopathy was a "condition." *Culley*, 72 Van Natta at 721. Given that concession, we decline to address SAIF's argument on remand. *See, e.g., Elvia*

To establish the compensability of his new/omitted medical condition claim, claimant must prove that the claimed condition exists, and that his work injury was a material contributing cause of the disability or need for treatment for the claimed condition.⁴ ORS 656.005(7)(a); ORS 656.266(1); *Betty J. King*, 58 Van Natta 977 (2006); *Maureen Y. Graves*, 57 Van Natta 2380 (2005).

This claim presents a complex medical question that must be resolved by expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Matthew C. Aufmuth*, 62 Van Natta 1823, 1825 (2010). Absent persuasive reasons to the contrary, we generally give greater weight to the opinion of an attending physician. *Weiland v. SAIF*, 63 Or App 810, 814 (1983). However, we may properly give more or less weight to the opinion of the treating physician depending on the record in each case. *Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001). More weight is given to those medical opinions that are well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Here, the record persuasively establishes the existence of the claimed L5-S1 radiculopathy condition, and that the July 2015 work injury was a material contributing cause of the need for treatment or disability for the claimed condition. We reason as follows.

As detailed above, Dr. Herring opined that the decedent's work injury was the major contributing cause of his radiculopathy condition. (Ex. 88-5). Dr. Herring based his opinion on the mechanism of injury (a "forceful event"), the decedent's consistent symptoms and credible examinations, the transient relief of symptoms that he experienced after receiving anti-inflammatory steroid injections, and Dr. Balm's abnormal "EMG" findings that showed objective evidence of S1

Garcia-Solis, 73 Van Natta 431 (2021) (declining to address carrier's argument regarding the existence of a "condition" when the carrier conceded at a prior level that claimant's symptoms were a "condition"); *Ian M. Reach*, 72 Van Natta 174 (2020).

Even if we did consider this argument, Dr. Herring opined that the decedent's radiculopathy constituted a condition, which he described as the physical status of a human body part. (Ex. 8-3). Thus, we find his unrebutted opinion sufficient to establish the existence of the decedent's claimed radiculopathy as a "condition." See *Young v. Hermiston Good Samaritan*, 223 Or App 99, 105 (2008) (a "condition" is defined as "the physical status of the body as a whole * * * or of one of its parts."); see also *Armenta v. PCC Structural, Inc.*, 253 Or App 682, 692 n 7 (2012) (whether a claim is for a medical "condition" is a question of fact to be decided on the medical evidence in individual cases).

⁴ SAIF does not assert a "combined condition" defense of its denial. See ORS 656.005(7)(a)(B); ORS 656.266(2)(a).

radiculopathy. (Ex. 88-4-6, -8). In light of the decedent's symptoms of left foot weakness, numbness and pain, a positive straight leg test on the left, and the EMG showing S1 radiculopathy, Dr. Herring concluded that the decedent had a pattern of nerve root symptoms and findings consistent with nerve root irritation, and that, to a reasonable probability, his complaints were consistent with a lumbar radiculopathy related to the work injury. (Ex. 88-4-5).

In reaching this conclusion, Dr. Herring considered the decedent's preexisting left toe issues. In particular, Dr. Herring noted that the problem had resolved and that the decedent was asymptomatic at the time of the work injury. (Ex. 88-5). He did not have concerns with the delay in the decedent's reporting of left foot numbness for "two weeks" when he treated with Dr. Yao on September 8, 2015. (Ex. 88-9). He explained that it was not unusual for patients to expect their symptoms to get better without having to treat with a physician. (*Id.*)

Dr. Herring is a neurologist who specializes in diagnosing and treating conditions like radiculopathy. (Ex. 88-2-3). The record establishes that he treated the decedent for approximately three years. Although he did not treat the decedent for approximately 14 months after the July 2015 injury, the record requires a finding that Dr. Herring had for his review all of the decedent's medical records, and was aware of his prior treatment and history for radicular-type symptoms. *Sullivan*, 319 Or App at 21. Moreover, the record requires a finding that Dr. Herring's opinion was based on accurate information and that, consistent with his opinion, the decedent complained of left foot pain to Dr. Yao two weeks after the injury. *Id.* Finally, the record establishes that Dr. Herring explained his reasoning that, despite the absence of back symptoms immediately following the injury, the decedent's history and diagnostics were consistent with L5-S1 radiculopathy. *Id.* Thus, under these particular circumstances, we find Dr. Herring's opinion persuasive and entitled to deference as the decedent's long-time treating physician with specialized expertise. *See Somers*, 77 Or App at 263; *Kevin G. Gagnon*, 64 Van Natta 1498, 1500 (2012) (physician's longitudinal history with the claimant rendered his opinion persuasive).

In contrast, Drs. Button and Rosenbaum opined that the decedent did not have a lumbar radiculopathy condition that was due to his work injury. Dr. Button explained that, because there are many causes of numbness in an extremity and the cause was often unknown, to support a diagnosis of radiculopathy, one needed to have "either electrical support from a nerve test, a history or exam consistent with pain, weakness, or numbness radiating down a leg, or it should generally be in conjunction with nerve compression seen in the lumbar spine." (Ex. 86-12). On

review of the record, Dr. Button found no evidence of any pain, weakness, or numbness actually radiating down the extremity (except for the foot numbness) until the decedent saw Dr. Herring 14 months after the injury. (*Id.*) Dr. Button stated that no provider found compression on imaging, and that the decedent had two electrodiagnostic and nerve conduction studies, neither of which, in his opinion, supported the presence of radiculopathy. (*Id.*) Ultimately, Dr. Button did not diagnose left lumbar radiculopathy and opined that the work incident was not a material contributing cause of his need for treatment for the condition. (Ex. 86-12, -14).

Dr. Rosenbaum could not identify a radiculopathy on the basis of the decedent's history, physical examination or imaging studies, noting in particular that the imaging studies demonstrated no nerve root compression. (Exs. 58-10, -12, 66-2). Although he stated that the decedent's mechanism of injury had the possibility of causing a lumbar radiculopathy, Dr. Rosenbaum concluded that there was no evidence in the medical record, including within the first year following the incident, that a lumbar radiculopathy or radiculitis occurred from the injurious event. (Ex. 58-11). He explained that signs of nerve root impingement demonstrating a radiculopathy are determined through clinical examination demonstrating neurological deficits such as motor, sensory, or reflex loss in expected dermatomal distributions in the leg consistent with the specifically affected nerve root. (Ex. 66-1). Dr. Rosenbaum noted that the decedent did not have neurological signs of nerve root compression, nor did he have historical subjective complaints of the signs of nerve root compression. (*Id.*) He specifically disagreed with Dr. Herring's opinion that the decedent had clinical evidence of lumbar radiculopathy, stating that neither Dr. Herring's chart notes nor those of any other examiner indicate lumbar radiculopathy in a specific dermatomal pattern as evidenced by motor, sensation, or reflex loss. (*Id.*)

Dr. Herring responded to the opinions of Drs. Rosenbaum and Herring. Although Dr. Herring agreed that the MRIs demonstrated no evidence of nerve root compression, he stated that compression was not the only source of radiculopathy. (Ex. 88-7). In the absence of obvious compression, Dr. Herring explained that annulus fibrosis tears can release disc fluid with an inflammatory component that will provoke an auto-immune reaction resulting in nerve root radiculopathy, and that such tears do not necessarily show up on MRIs. (*Id.*) In the decedent's case, Dr. Herring believed that the bicycle incident was of sufficient force to "probably cause a small rent in his annulus which leaked irritants and caused chronic inflammatory changes around the S1 nerve root." (*Id.*) Drs. Rosenbaum and Button did not address this portion of Dr. Herring's opinion.

See Janet Benedict, 59 Van Natta 2406, 2409 (2007), *aff'd without opinion*, 227 Or App 289 (2010) (medical opinion found unpersuasive when it did not address contrary opinion).

Moreover, in response to Dr. Button's opinion that the nerve conduction studies did not establish the presence of the condition, Dr. Herring acknowledged Dr. French's earlier NCV, but explained that it did not include an EMG, which is used to determine whether a patient is experiencing radiculopathy. (Ex. 88-8). Moreover, he explained that Dr. Balm's EMG findings of "mild, old" left S1 radiculopathy findings did not establish that the decedent was asymptomatic, and noted that the EMG was performed nearly one-and-a-half years after the work incident and, therefore, would be too late to expect acute findings.⁵ (Ex. 88-9). Dr. Button did not respond to this portion of Dr. Herring's well-reasoned opinion. *Benedict*, 59 Van Natta at 2409.

Finally, regarding the criticism from Drs. Button and Rosenbaum regarding the delay in radicular-type findings for 14 months post injury, Dr. Herring explained that the decedent had left foot complaints consistent with the claimed condition within two weeks. (Ex. 88-9). This finding is supported by the record. *Sullivan*, 319 Or at 21. Moreover, he noted that the orthopedists in the claim evaluated the decedent's left foot complaints as potentially related to ankle and knee conditions, because they tend to look for joint-related explanations and provide treatment within their particular specialties. (Ex. 88-9-10).

Under these particular circumstances, we find the better-explained and reasoned opinion of the decedent's long-time treating physician and specialist, Dr. Herring, more persuasive than the opinions of Drs. Button and Rosenbaum.⁶ In particular, Dr. Herring's opinion is based on a complete and accurate history, well reasoned, based on his clinical evaluations over time and the decedent's particular circumstances, and sufficiently responsive to the opinions of Drs. Rosenbaum and Button. In contrast, Drs. Button and Rosenbaum did not sufficiently address

⁵ Dr. Herring further noted that, in reaching this conclusion, he specifically discussed these findings with Dr. Balm. (Ex. 88-3).

⁶ In reaching this conclusion, we acknowledge SAIF's argument that Dr. Herring initially had two working diagnoses – a lumbar radiculopathy and posttraumatic piriformis syndrome. Yet, over multiple examinations, imaging studies, and additional nerve conduction studies, he concluded that the decedent more likely had a lumbar radiculopathy condition. We further note that lumbar radiculopathy was among those alternative diagnoses, and that Dr. Herring consistently attributed the condition to the work incident. Consequently, we decline to discount his opinion regarding the decedent's evolving diagnosis.

significant aspects of Dr. Herring's reasoning to support his opinion relating the radiculopathy condition to the decedent's work injury.⁷ *See Somers*, 77 Or App at 263; *Gagnon*, 64 Van Natta at 1500; *Craig C. Show*, 60 Van Natta 568, 576-77 (2008) (finding the more detailed, accurate, and better-explained medical opinion to be persuasive). Thus, based on Dr. Herring's persuasive opinion, the record establishes the existence of the claimed radiculopathy condition, and that the work injury was a material contributing cause of the need for treatment for the claimed condition.

In sum, for the aforementioned reasons, we find claimant's new/omitted medical condition claim for a left L5-S1 radiculopathy condition compensable. ORS 656.005(7)(a); ORS 656.266(1). Accordingly, we set aside SAIF's denial.

Claimant's attorney is entitled to an assessed attorney fee for services at the hearing level, on Board review, and on remand before the Board regarding the compensability of the L5-S1 lumbar radiculopathy condition.⁸ ORS 656.386(1); ORS 656.388(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for services at those levels is \$21,500, payable by SAIF.⁹ In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, the value of the interests involved, the risk that counsel may go uncompensated, and the contingent nature of the practice of workers' compensation law.

Finally, claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial of left L5-S1 lumbar radiculopathy condition, to be paid by SAIF. *See* ORS

⁷ Moreover, Drs. Button and Rosenbaum primarily opined that the decedent did not have a radiculopathy condition related to his work injury because they did not diagnose a radiculopathy condition. Because the record persuasively establishes the existence of that condition, we further discount their opinions. *See Jimmy D. Folkens*, 68 Van Natta 1221, 1224 n 3 (2016) (opinion of physician who did not believe that the disputed lumbar radiculopathy condition existed was unpersuasive regarding causation when the medical evidence established the existence of that condition).

⁸ The court granted claimant's counsel a total of \$49,496 in attorney fees for services before the Court of Appeals and the Supreme Court, contingent on claimant prevailing on remand.

⁹ Claimant was represented by different counsel at the hearing level. Nevertheless, the attorney fee award for claimant's attorneys services is granted to the attorney of record, with the specific distribution of that award to be resolved by claimant's current and former attorneys. *See Orlando M. Gongora*, 63 Van Natta 1003, *recons*, 63 Van Natta 1127 (2011).

656.386(2); OAR 438-015-0019; *Nina Schmidt*, 60 Van Natta 169 (2008); *Barbara Lee*, 60 Van Natta 1, *recons*, 60 Van Natta 139 (2008). The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

Accordingly, on reconsideration of the Board's August 3, 2020, order, that portion of the ALJ's November 14, 2019, order concerning the compensability of claimant's new/omitted medical condition claim for a left L5-S1 lumbar radiculopathy condition is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at the hearing level, before the Board on review, and before the Board on remand regarding the compensability of the L5-S1 lumbar radiculopathy condition, claimant's counsel is awarded \$21,500, to be paid by SAIF.¹⁰ The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

Entered at Salem, Oregon on April 21, 2023

¹⁰ This fee is in addition to the attorney fee awards granted by the court.